# UnitedHealthcare Community & State

## Hoosier Care Connect Health Plan

## Prior Authorization 201

Presented by Jodie Hattery, VP Provider Relations IN, KY and OH

United Healthcare®

# Our Service Lines

- UnitedHealthcare


- Optum Behavioral Health


- March Vision


- UnitedHealthcare Dental

# Prior Authorization Requirements for Indiana Hoosier Care Connect

**Effective June 1, 2021**

Prior authorization: Requesting medical necessity review and approval before rendering a service is required by UnitedHealthcare policy for some services. It's required under the direction of the UnitedHealthcare Health Services Department and is an essential part of any managed care organization. Advance notification is required to give UnitedHealthcare timely communication of services so we can do a prospective, concurrent and retrospective care review.

*Prior authorization is ***not required*** for emergency or urgent care.

# Admission Notification

**Admission Notification:** General Acute Care and Nursing facilities are required to notify UHC when a member has been admitted into their facility as an Inpatient. This must be done within 24 hours (also referred to as “head in the bed”) of member admission.

Notify UnitedHealthcare of an Admission

a) Via Phone

b) Via fax paper form

c) Online – easiest and most efficient method

d) Electronic Data Interchange (EDI) 278N Transaction

# Admission Notification - EDI 278N Transaction

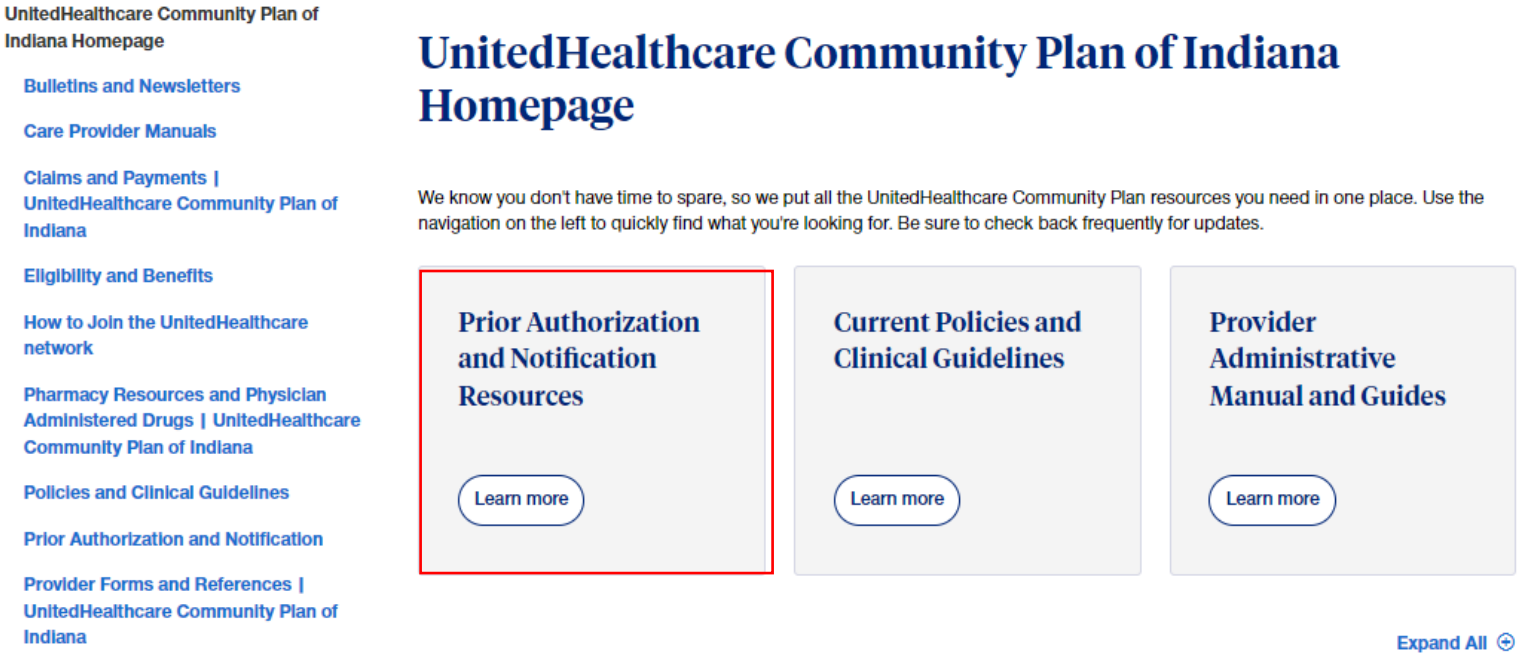
- Use the Hospital Admission Notification (278N) transaction to exchange admission notification data between an inpatient facility and UnitedHealthcare in a standard format
- It can be transmitted directly to UnitedHealthcare or through a clearinghouse in either batch or real-time format
- To get started, contact your vendor or clearinghouse
- Most clearinghouses already send 278N transactions to UnitedHealthcare and can work with you to submit notifications in the appropriate format
- For additional information regarding the EDI 278N Transaction please visit our website at: EDI 278N: Hospital Admission Notification | UHCprovider.com

# MEDICAL

# **Medical** How to Check Prior Authorization Requirements

## Providers can check Prior Authorization requirements at:

[UnitedHealthcare Community Plan of Indiana Homepage | UHCprovider.com]



# **Medical** How to Check Prior Authorization Requirements

## Prior Authorization and Notification | UnitedHealthcare Community Plan of Indiana

We have online tools and resources to help you manage your practice's notification and prior authorization requests.

**Need to submit or check the status of a prior authorization request? Go to UHCprovider.com/priorauth to learn about our Prior Authorization and Notification tool.**

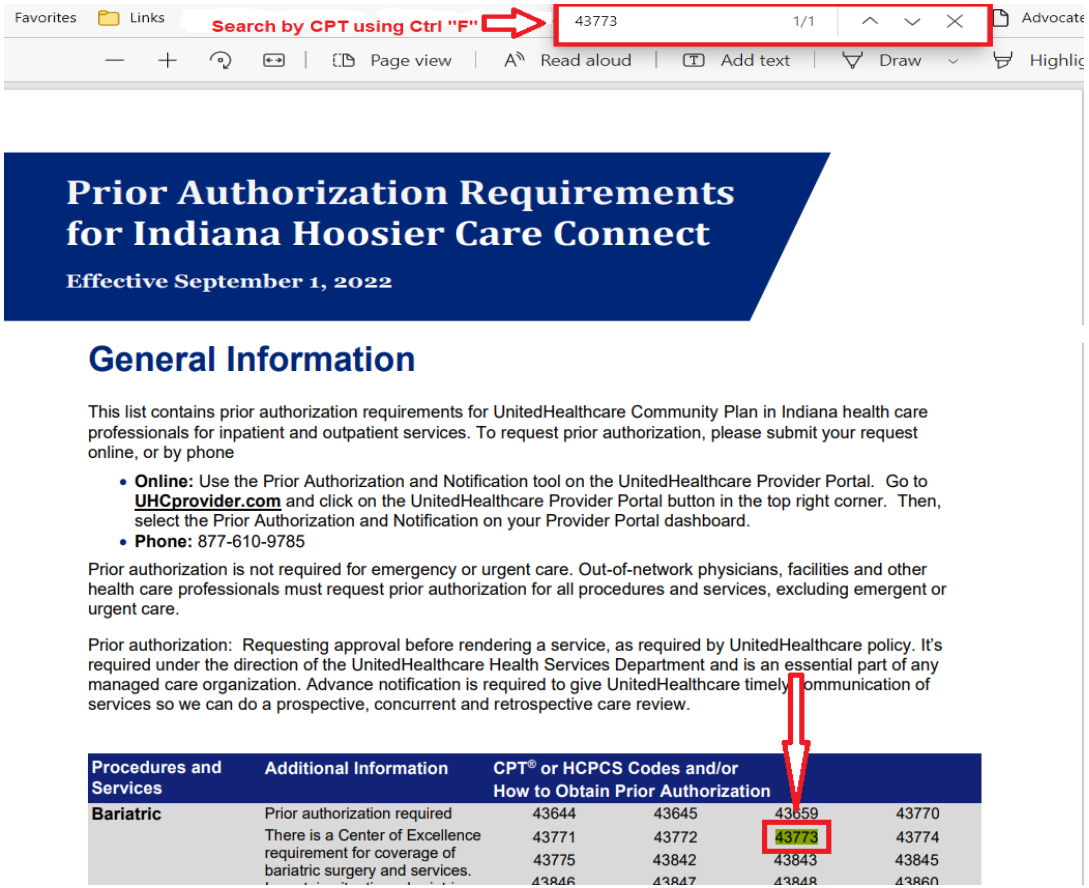
Go to Prior Authorization and Notification Tool

### Current Prior Authorization Plan Requirements

- UnitedHealthcare Community Plan Prior Authorization Indiana Hoosier Care Connect - Effective Sep. 1, 2022

# **Medical** How to Check Prior Authorization Requirements

[UnitedHealthcare Community Plan Prior Authorization Indiana Hoosier Care Connect - Effective Sept. 1, 2022 (uhcprovider.com)]



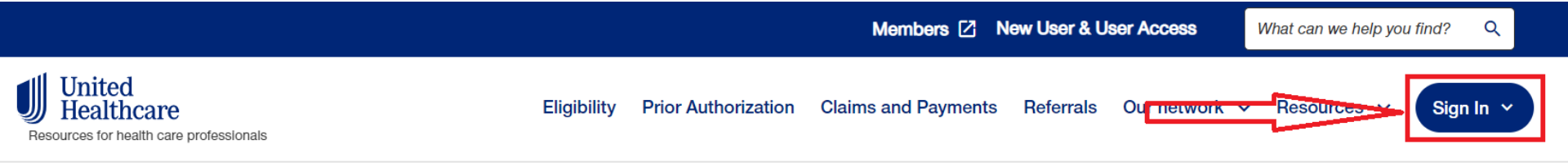
# Medical How to Check Prior Authorization Requirements Via PAAN

**Use the Prior Authorization and Notification Tool via our UnitedHealthcare Provider Portal to:**

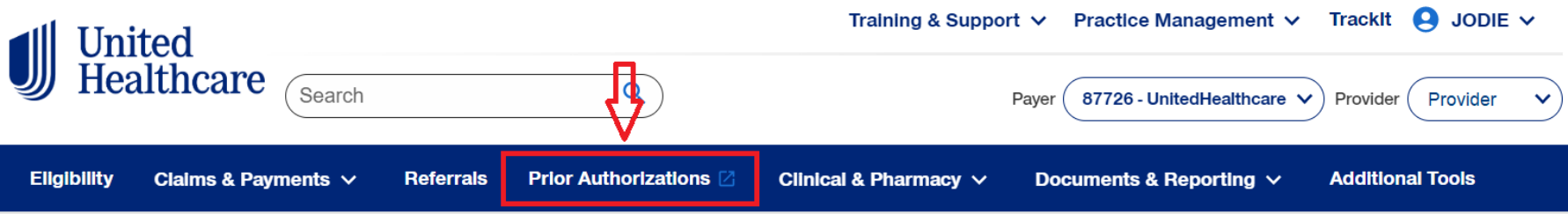
- Determine if notification or prior authorization is required
- Complete the notification or prior authorization process
- Upload medical notes or attachments
- Check request status Information and advance notification/lists

# **Medical** How to Check Prior Authorization Requirements Via PAAN

**From the www.uhcprovider.com homepage click on "Sign In"**




**After logging into our UnitedHealthcare Provider Portal, click on "Prior Authorization"**



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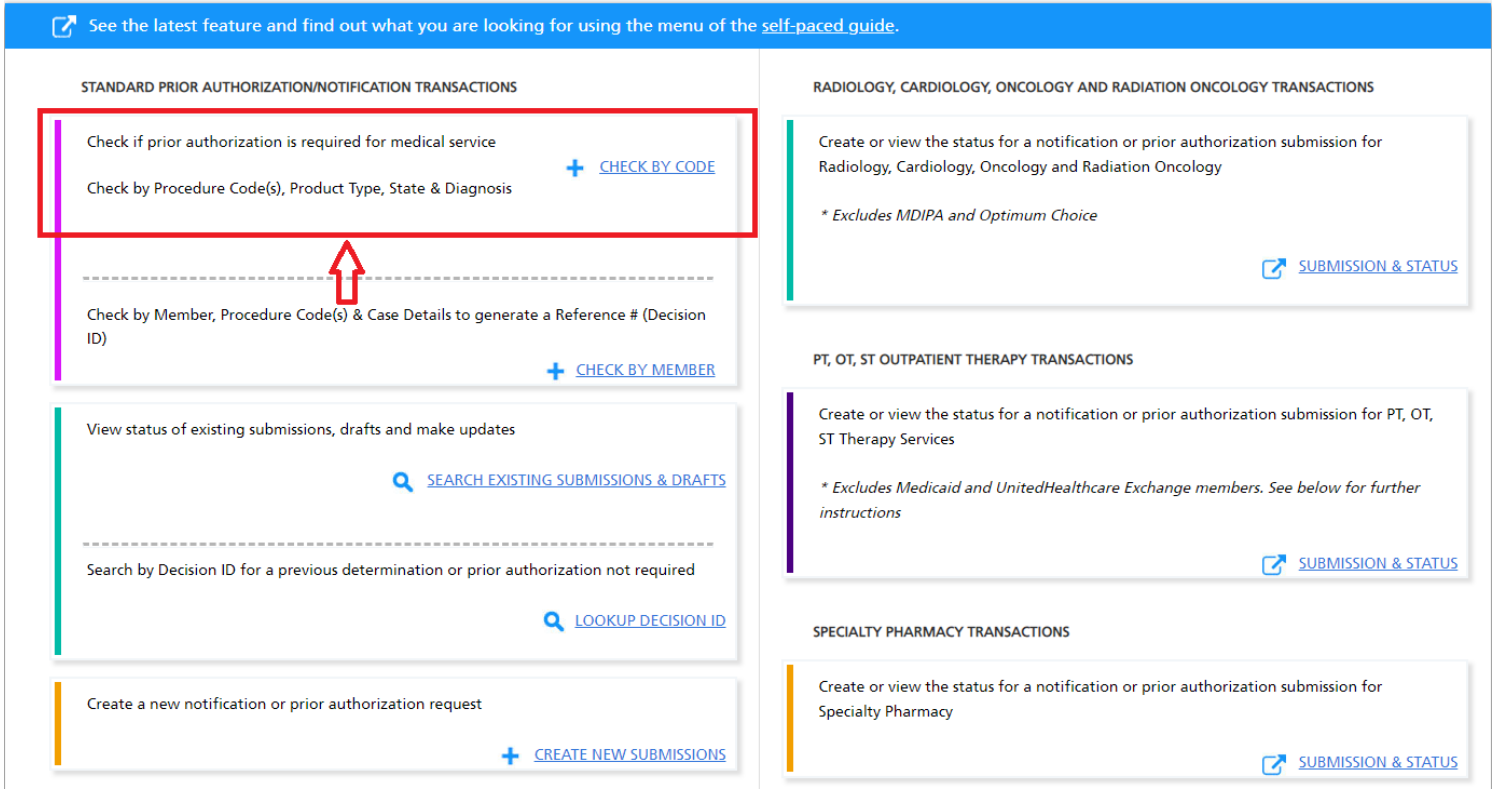


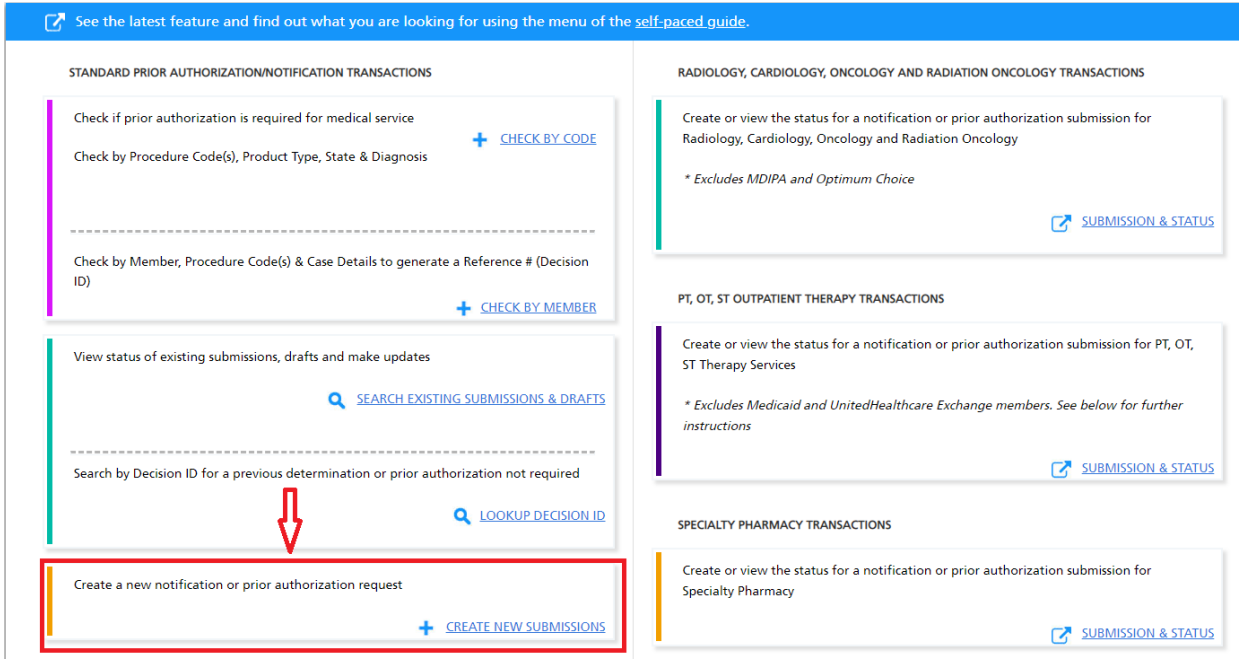
# Medical How to Request a Prior Authorization

## How to submit Prior Authorization once you have confirmed it is required:

a) Via fax paper form

b) Via phone: 877-610-9785

c) Online via the PAAN Tool



# MEDICAL Prior Authorization Submission Tips

- If the provider you are trying to select is not an option, select another provider within the group for the authorization
- Use the “Find Facility” search tool
- Use the wildcard symbol (*) to help you find the results you are looking for.  Typing in less with a wildcard will help return the results you are looking for
- UnitedHealthcare Community Plan uses InterQual for medical care determinations
- You can access our UnitedHealthcare Community Plan of Indiana Clinical Guidelines here

# MEDICAL Tips to Avoid Prior Authorization Denials

- Be thorough and complete all the requested documentation
- Ensure that you are answering all authorization questions

## Medical Management Guidelines

### Admission authorization and guidelines

All prior authorizations must have the following:

- Patient name and Medical ID number
- Ordering care provider or health care professional name and TIN/NPI
- Rendering care provider or health care professional and TIN/NPI
- ICD-10 Diagnosis Codes
- Anticipated date(s) of service
- Primary and secondary procedure code(s) and number of units or visits, etc., when applicable
- Service setting
- Facility name and TIN/NPI, when applicable

# Medical Avoiding Adverse Determinations and/or Peer-to-Peer Reviews

- Problem: UHC often does not receive complete clinical information with the authorization request to make a medical necessity determination
  - Following the suggestions below will result in less adverse determinations, more timely decision turn-around-times, a reduction in the need for Peer-to-Peer reviews and/or requests for additional clinical information:
    - Submitting Prior Authorizations online via the PAAN tool
    - Submission of all required clinical information
    - Completion of all fields within the online request leaving no fields blank and avoiding answering with “N/A”

# Medical

## Prior Authorization Requests Must be Timely

- Problem: UHC does not receive ***routine*** Prior Authorization requests for scheduled services well in advance of the service date.
    - Submit your Prior Authorization request online, via the PAAN tool as soon as the service/procedure is scheduled.  For example, if a surgery is scheduled two months in advance, submit the Prior Authorization as soon as possible after scheduling.  This will result in a timely determination well in advance of the scheduled service date.

# **Medical** Peer-to-Peer Process

- Peer-to-Peer reviews can be requested 7 calendar days from verbal notification of an adverse determination (this includes Inpatient Level of Care denials)
- If your request is denied you may request a Peer-to-Peer by calling 800-955-7615
- A Peer-to-Peer review should be requested by facilities when Inpatient Level of Care is Denied
- A Peer-to-Peer review can also be requested if a Prior Authorization for a scheduled procedure is denied
- A Prior Authorization request that does not meet coverage criteria or lacks sufficient information upon submission may “pend” for a Peer-to-Peer

# Medical Avoiding Adverse Determinations and/or Peer-to-Peer Reviews

As mentioned in slide 15, completion of all fields within the online request, leaving no fields blank and avoiding answering questions with “N/A”, will result in more timely decisions.

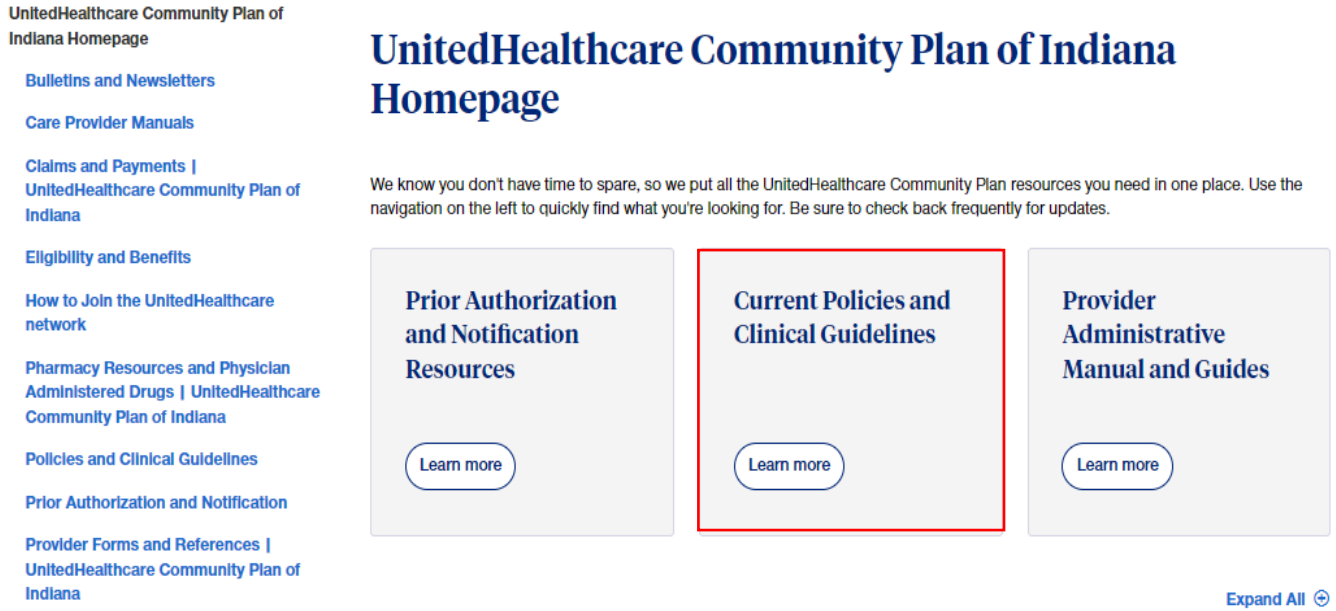
The best way to accomplish this is to be familiar with the Clinical/Medical Policies that apply to the service you are requesting Prior Authorization for.

For example, a provider that specializes in Bariatric Surgery should be familiar with our Community Plan of Indiana’s “Bariatric Surgery” Medical Policy.

# Medical

## Be Familiar with our Clinical Policies

- You can view our Clinical Policies at www.uhcprovider.com/INcommunityplan



# Medical

## Be Familiar with Clinical Policies

- Bariatric Surgery
  - UHC follows in this order:
    - State and Federal Medical Policy Regulations
    - UnitedHealthcare Medical Policy
    - InterQual Medical Policy

**Bariatric Surgery (for Indiana Only) – Community Plan Medical Policy**

Last Published 04.01.2021

Effective Date: 04.01.2021 – This policy addresses bariatric surgical procedures, including gastric bypass, gastric banding, sleeve gastrectomy, biliopancreatic bypass, and biliopancreatic diversion with duodenal switch.

## Indiana Medicaid Bariatric Surgery Medical Policy

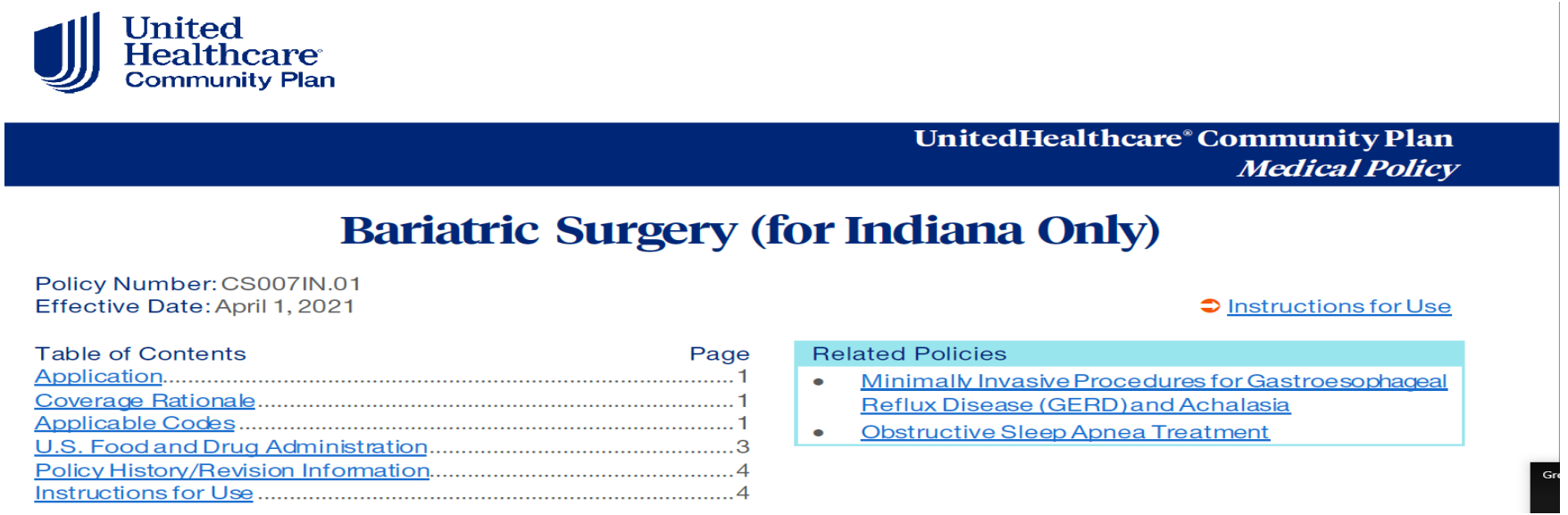
https://www.in.gov/medicaid/providers/files/surgical-services.pdf.

### Bariatric Surgery and Revisions

Bariatric surgery is recognized as medically necessary when used for the treatment of morbid obesity. Providers must report ICD-10 diagnosis code E66.01 – *Morbid obesity* with the most specific procedure code available that represents the procedure performed.

# Medical Clinical Policies

- UHC Medicaid Bariatric Surgery Medical Policy
- https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan/in/bariatric-surgery-in-cs.pdf.



United Healthcare Community Plan

UnitedHealthcare® Community Plan
*Medical Policy*

## Bariatric Surgery (for Indiana Only)

Policy Number: CS007IN.01
Effective Date: April 1, 2021

Instructions for Use

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Related Policies

- Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia
- Obstructive Sleep Apnea Treatment

# Medical

## Process to Dispute a Prior Authorization Decision & File Appeal

- When there is an initial adverse determination of a prior authorization request:
  - Provider's next available step is a Peer-to-Peer review
  - If the denial is upheld, the provider can then appeal the determination
  - If no Peer-to-Peer was requested and an appeal was filed, then the provider is no longer eligible for a Peer-to-Peer
  - Provider will receive a letter of adverse determination; it will detail steps needed to request a Peer-to-Peer and/or an appeal

# Medical

## External Review

- When requested, an external review of a Prior Authorization can be performed by an Independent Reviewer Organization (IRO)
- Member must file the external review request within 120 calendar days from receiving the appeal decision
- We utilize the State's recommended list of Independent Review Organizations (IROs) to conduct the external review
- A decision by the IRO is made within 72 hours if expedited and within 15 business days for standard appeals
- The decision by the IRO is binding and not disputable by UnitedHealthcare

# Medical

## State Fair Hearings

- FSSA maintains a fair hearing process which allows members the opportunity to appeal the Contractor's decisions
- Members must first exhaust all grievance and appeal options with UnitedHealthcare
- Members may file for a State Fair Hearing within 120 calendar days from the adverse determination notice of the final appeal
- The member and member's representative as well as a representative of UnitedHealthcare attends the hearing
- If the member is dissatisfied with the outcome of the hearing, they may request an Independent Review Organization (IRO) review within 10 days of the administrative law judge's decision

# **Medical** Retroactive Authorizations & Medical Claim Review

- Retroactive Authorization:
    - Retroactive Authorizations will be issued when the “No Authorization” denial was due to eligibility issues
- Medical Claim Review (MCR) performs Medical Necessity reviews on denied claims when a Prior Authorization/Admission Notification was not obtained or if Inpatient Level of Care was denied during the members Inpatient stay
    - Example: Provider obtains authorization for a particular code, then upon entering the surgical site the provider must perform an additional or different service than what was originally approved
    - The claim would be filed, denied and then reviewed by the Medical Claim Review team upon submission of a Claim Reconsideration with documentation that supports Medical Necessity attached

# Your Medical Network Provider Advocate Team

**Nneka Nelson**
763-361-0100
nneka_m_nelson@uhc.com

**Lori Reeder**
763-321-3822
lreeder@uhc.com

**Karen Cockerham**
618-943-6693
karen.cockerham@uhc.com

**Kim Berry**
612-395-8106
kim_berry@uhc.com

**Cincinnati Market**
800-752-7106
SW_OH_team@uhc.com


**Jen Smith**
Manager
952-406-6498
smithjen@uhc.com

**Jodie Hattery**
VP, Provider Market Ops
952-406-6449
jodie_hattery@uhc.com

# Your FQHC Provider Advocate Account Manager

**Kelly Carpenter**
All Indiana FQHC's
763-348-6102
kelly_carpenter@uhc.com

# Questions and Answers

Thanks for Attending Today’s Session

# Provider Reference Appendix

Provider Service Line Website Links

- United Health Community Plan (Medical): www.uhcprovider.com/INcommunityplan
- UHC Dental: www.uhcdentalproviders.com
- MarchVision: www.marchvisioncare.com
- Optum Behavioral Health: www.providerexpress.com